The Filling of Cranial Osseous Defects with Charred Bone-plates.—GREKOFF (*Centralblatt für Chir.*, October 1, 1898) has employed in actual practice the method which Barth found valuable in experiments. In the cases of two young children who had, as the result of operation after serious injury, defects in the cranial bones, he used the charred bone with success. In one instance all the plates were not sufficiently charred, and he was obliged to remove some fragments. This gave him the opportunity to observe the actual condition in the remaining plates. He found that the results were all that could be desired, and that the charred plates had been replaced by new, healthy bone.

The function of the charred bone, the author believes, is solely that of a skeleton over which the new bone develops from the adjacent margins of the skull. The cancellated bone is, therefore, most readily penetrated and absorbed, and makes the best plates. In his cases he employed the scapulæ of the calf.

Bier's New Osteoplastic Amputation.—PAYR (*Centralblatt für Chir.*, 1898, No. 19) reports three cases in which this new osteoplastic method of amputation was employed with success, as demonstrated by a skiagraph taken a year after the operation.

The purpose of the method is to unite the extremities of the tibia and fibula by an osteoperiosteal flap, which is derived from the tibia in the following manner:

A musculo-cutaneous flap is formed from either the anterior and external or the anterior and internal aspect of the leg in the ordinary manner. The tibia is freed to a considerable distance below the point at which it is desired to amputate. A transverse incision is then made at a distance below the line of amputation equal to the length of the desired bone-flap. This incision forms the base of a wedge-shaped portion of the tibia, that after removal permits the insertion of a flat saw-blade and the cutting of the osteo-periosteal flap up to the line of amputation. The periosteum is now raised over the line of amputation at the base of the osteoperiosteal flap. A grooved director is passed beneath the periosteum, and with a narrow saw the portion of the bone-flap is removed, which will permit it to bend over without interfering with the circulation on which it depends for its nutrition. When this has been accomplished the flap of bone is turned back and the tibia cut through. The fibula is cut at the same level, and the osteoperiosteal flap is fastened upon the resected ends of the two bones. The wound is closed in the usual manner. Asepsis or the use of only non-irritating antiseptics is essential to the success of this operation. The Röntgen ray picture showed that the osteoperiosteal flap had retained its original thickness throughout, and that it was firmly united to both the tibia and fibula. The functional result attained was all that could be desired.

The Diagnosis of Nephrolithiasis by Röntgen Ray Pictures.—RINGEL (*Centralblatt für Chir.*, December 10, 1898) has followed out the experiments of some of the earlier investigators and has found that the different forms of renal calculi vary in their opacity to the Röntgen rays.

Oxalic-acid calculi are the most opaque, uric-acid calculi are less opaque, while the quality of Röntgen ray he employed readily penetrated the phosphatic calculi and biliary calculi.

Repeating the experiments on the cadaver, his results conincided with those of the earlier observers. The more opaque calculi could be shown, but the less opaque were readily penetrated and could not be detected.

His conclusions are the same as those of the earlier observers, that the positive diagnosis is the only one that can be relied upon, as certain calculi may be present, but cannot be detected.

[This author probably employed a "hard" tube, and in consequence penetrated the less opaque calculi. Clinical experience has recently demonstrated that an absolute diagnosis, both positive and negative, can be made. Sufficient Röntgen discharge can be developed in a "soft" tube of the latest design to penetrate the lumbar region, and yet the quality of the light is such that it will differentiate between the lesser densities, and show all forms of calculi in contrast to the surrounding structures.]

Coxa-vara.—In reporting a case BRUN (*Revue d'Orthopêdie*, November, 1898) says that coxa-vara is revealed by defects in the manner of walking. The child stumbles at every step, especially if he is permitted to walk alone. By careful concentration of the mind upon the walking he is able to correct the defects. The walk is like that of double congenital luxation. The case reported was mistaken for this. The author could not, however, locate the heads of the femora, and in order to be more certain had a radiograph taken. The diagnosis was thus cleared up. The fact which the author would call particularly to notice is that the radiograph has given positive knowledge of the existence of this deformity.

KIRMISSON (*Ibid.*), in discussing the same subject, says that a series of carefully studied and reported cases in which radiographs are employed are essential before the origin of this deformity can be definitely determined. There can be no doubt that there are various causes for it, but the only way to determine what they are is the collection of a large number of cases.

To the causes already enumerated he would add fracture of the neck of the femur, which he believes is less infrequent than has been supposed. It is not possible to make the diagnosis of coxa-vara without the employment of radiographs, no matter what the clinical conditions are that are present in the case.

In making a résumé of his work upon this subject, FABRIKANTE (*Revue de Chir.*, November 10, 1898) says:

1. The affection commonly called coxa-vara is most frequently of rhachitic origin, and is characterized by an incurvation of the neck of the femur.
2. This incurvation may consist (*a*) in a deviation of the neck of the femur downward, with the angle between the neck and the shaft of the femur diminished; (*b*) deviation in advance or backward, with a coincident curve in its longitudinal axis.
3. The greater the curve the less result can be hoped for from orthopedic treatment.
4. In cases requiring operative treatment the preferable thing to do is to remove a wedge-shaped piece from the neck of the femur; its base should be upward.